STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING 00 B. WING	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPARK REHABILITATION CENTER	25 S BOEHNE CAMP ROAD EVANSVILLE, IN47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a recertification and state licensure survey. Survey dates: July 25, 26, 27, 28, 2011 Facility number: 000221 Provider number: 155328 Aim number: 100267620 Survey team: Amy Wininger, RN, TC Diane Hancock, RN Census bed type: SNF/NF: 84 SNF: 11 Total: 95 Census payor type: Medicare: 7 Medicaid: 70 Other: 18 Total: 95 Sample: 19 Supplemental Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2 Quality review completed 7/29/11	F0000	The Preparation or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. We respectfully request this Plan of Correction serve as our allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Cathy Emswiller RN			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure supervision and assistive devices were provided to prevent accidents, for 1 of 7 sampled residents reviewed for falls, in the sample of 19, and for 1 of 1 supplemental sample resident reviewed for falls, in the supplemental sample of 3, in that one resident was repositioned with one staff member, with assessments indicating the need for two, and the resident fell to the floor resulting in a subdural hematoma, and one resident had repeated falls without changes in interventions. (Residents #56, #97) The facility also failed to ensure 1 of 1 resident reviewed for elopement was provided supervision to prevent exiting the building, following attempts to exit, and then she was successful in exiting the building. (Resident #48) Findings include: 1. On 7/27/11 at 10:40 a.m., resident #	F0323	F 323 Resident # 56's most recent Minimum Data Set was reviewed and care plans and CNA assignment sheets were updated to ensure adequate supervision/assistance and assistive devices are provided to prevent accidents based on current assessed needs. Resident # 97 no longer reside in the facility. Supervision and interventions (placement of wander guard) are being provided to resident # 48 to prevent resident from exiting the facility and care plans, CNA assignment sheets were updated as indicated. A 100% audit of Minimum Data Sets was completed on facility residents and then reviewed by the interdisciplinary team to determine that interventions are appropriate and adequate supervision/assistance is provided. Care plans and CNA assignment were updated as indicated to prevent accidents based on current assessment. Residents identified to be at risk for elopement were reassessed	08/27/2011

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	56 was observed being taken out of the building on a stretcher. LPN #2 and RN #1 indicated it was Resident #56 and she had fallen. When queried, they indicated she had an air mattress and 1/4 siderails and she had fallen from bed. When queried further, they indicated she was being turned by a staff member and fell out of bed. When queried about staff present during the turning and repositioning, they indicated there was only one staff member, that she only required one. They indicated she had a "goose egg" on her forehead and they were sending to the emergency room. They indicated she was alert and talking and had told the CNA not to worry, it was just an accident. Resident #56's clinical record was reviewed at 11:00 a.m. on 7/27/11. The most recent Minimum Data Set Assessment [MDS], a quarterly assessment dated 7/4/11, indicated the resident required extensive assistance of two plus staff for bed mobility. The care plan, dated 12/9/10, indicated she was on a Bed Mobility Program. The program indicated, "4-5 inch roll to be placed under knees while in bed. There will be no breakdown. Resident to be cued to assist with bed mobility. CNA to keep pillow case clean and dry. Report to nurse any skin breakdown." The goal		and care plans and interventions revised as needed. Facility doors were equipped with locking devices and require a code to exit along with a wander guard system. Staff were re-educated regarding accident prevention, appropriate accident interventions, and staff supervision. The Resident Daily Acuity Report (daily report that shows increase or decrease in resident's ADL's) and new comprehensive assessments will be audited daily by the ADON/designee to identify changes in residents condition. Results of audit will be reviewed by interdisciplinary team to ensure that interventions are appropriate and adequate supervision/assistance is provided. Proper documentation, placement, and function of wander guard is audited 5 x weekly by designee. Audits will be ongingAudits will be reviewed daily 5 X week by the administrator /designee to ensure completion and accuracy. Identified non compliance with POC interventions will result in 1:1 re-education with progressive discipline up to and including termination. Results of the audits are reviewed for 6 months by the QA committee for recommendations. Systemic changes will be completed by 8-27-11	

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	indicated, "Resident continue to help with bed mobility, no breakdown noted." Program notes included, but were not limited to, the following: "9/30/10 3:00 PM ...Resident given verbal cues to assist with bed mobility..." The resident's ADL [Activities of Daily Living] reports, completed by CNAs by computer, were provided by the Minimum Data Set [MDS] coordinator, on 7/27/11 at 4:00 p.m. The reports indicated the resident was provided limited to extensive assistance of one person for bed mobility, except for the following dates and shifts: 7/10/11 Shift 2 total assist of 2 staff, 7/12/11 Shift 2 extensive assistance of 2 staff, 7/14/11 Shift 2 extensive assistance of 2 staff, 7/15/11 Shift 2 extensive assistance of 2 staff, 7/17/11 Shift 2 extensive assistance of 2 staff, 7/18/11 shift 2 total assist of two staff, 7/19/11 Shift 3 extensive assistance of 2 staff, 7/20/11 Shift 2 total assist of 2 staff, 7/22/11 shift 2 extensive assist of 2 staff, 7/23/11 Shift 2 extensive assist of 2 staff, 7/26/11 Shift 2 total assist of 2 staff. Nurses' notes included, but were not limited to, the following: "7/4/11 2 AM Res [resident] resting quietly in bed, resp [respirations] WNL [within normal limits], skin W/D [warm and dry], requires assist of i [one] for			

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	ADL's, ii [two] assist for bed mobility, hoyer [mechanical] lift for transfers, incont [incontinent] bowel, F/C [foley catheter] patent et draining cl [clear] yl [yellow] urine, able to voice wants et needs, call light in reach." "7/27/11 10 a [a.m.] Called to res. room res. lying on floor on back on (L) [left] side of bed. During care res. tumbled out of bed 3.7 cm [centimeter] X 1.2 cm hematoma noted [with] laceration [with] large amt [amount] of blood. Applied pressure. Able to get hematoma to stop bleeding. Pupils equal [and] reactive to light. Transferred res. back to bed [with] hoyer [with] 4 assist." The Accident/Incident Report, in the clinical record, indicated the following: "CNA doing care rolled res. over [and] res. fell on floor." The Immediate Action taken to Prevent Further Incidents was "2 assist for ADL's, bariatric bed [with] bolsters [with] 1/2 SR's [siderails]." On 7/27/11 at 2:40 p.m., LPN #2 provided the Nursing Assistant Assignment Worksheets. They had been updated on that date. The Assistant Director of Nursing #1 [ADON] and LPN #2 indicated, at that time, the sheets had just been updated for Resident #56. She had previously been identified as an assist of 1 staff with 1/4 siderails. The current			

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	direction was for 2 assist and 1/2 siderails. Both staff members indicated she had always been turned with one person before. CNA #2 was interviewed, at 4:35 p.m. on 7/27/11. She indicated she turned the resident by herself, but she always turned her towards her, to prevent her going over the edge. The Director of Nursing [DoN] was interviewed, on 7/28/11 at 9:00 a.m. She indicated she had not realized what the MDS said, just what the staff were doing. "She's okay to turn [with] 1...if they are pulling her up in bed, they would use 2." She indicated the resident was on an air mattress and they were slick. She further indicated, "of course, from now on, she'll be 2 assist." She indicated the resident had been admitted to the hospital on 7/27/11 with a diagnosis of subdural hematoma. 2. Resident #97's clinical record was reviewed on 7/26/11 at 4:30 p.m. The resident's quarterly Minimum Data Set [MDS] assessment, dated 6/11/11, indicated the resident required extensive assistance of two persons for transfers, and had a history of falls in the assessment period.			

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	The resident's care plan for fall prevention and management, dated 3/28/11 and reviewed 6/13/11, indicated the resident required one person for transfers. Interventions included, but were not limited to, the following: High/Low bed, 1/4 siderails, bed/chair sensor Added in response to falls were the following: 2/18/11 non skid slippers 5/1/11 chair sensor 6/5/11 bed sensor staff educated 6/4/11 family educated 7/6/11 gripper socks applied 7/11/11 skin tear treatment. Resident 15 minute checks, staff inserviced. Nurses' notes included, but were not limited to, the following: -Accident/Incident Report, dated 6/5/11 at 6:45 a.m., "Resident ambulating self to toilet [with] use of walker and slippers on. Res. slipped in rm [room] fell to floor landing on buttocks. No apparent injury." The form indicated the resident required two for assistance getting up. The immediate action taken to prevent further incidents was "instructed res. to have staff assist to rest [restroom]." There was no indication of a bed sensor being in use or alarming. -Accident/Incident Report, dated 7/6/11 7:20 a.m., indicated "Resident from			

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bathroom to beside bed in w/c - attempted to sit on bed - sat on floor." The resident indicated, "There was a slick spot on the floor." The Immediate Action taken to prevent further incidents was to "[check] alarm - gripper socks."
-Accident/Incident Report, dated 7/11/11 at 4:00 a.m., indicated, "Res. ambulating to bathroom [without] assist fell to floor landing on buttocks. Res. turn bed alarm off." The resident received a skin tear to the right forearm. The Immediate Action to prevent further incidents was, "15 min [checks]."

On 7/27/11 at 3:20 p.m., the Director of Nurses [DoN] was interviewed. She indicated she was unsure about the alarm on 7/6/11. The resident was using alarms at that time. She indicated since they wrote "check alarm" on the report,it must not have been on. "She was known to turn them off; we'd hide them and she'd find them." The 7/11/11 fall indicated she had turned the alarm off. On 7/27/11 at 9:00 a.m., the DoN indicated any new interventions would have been noted on the care plan. She indicated the resident was an independent lady and she was not sure what would have worked, short of one on one care.

3. Resident #48's clinical record was reviewed on 7/25/11 at 10:05 a.m. The

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	resident was admitted to the facility 11/28/03. Her diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure, hypertension, and dementia. The resident's most recent full comprehensive assessment, dated 4/8/11, indicated no issues with behaviors. The assessment indicated she required extensive assistance of 2 staff for transfers and required assistance with all activities of daily living. The nursing progress notes had an Accident/Incident Report, dated 2/15/11 [no time], indicating, "Resident observed outside by staff member et returned to ICF [intermediate care facility] unit." The Immediate Action taken to prevent further incidents was "15 minute checks initiated, wanderguard placed on w/c [wheelchair], follow plan of care; toilet et put to bed [after] supper meal." A DCR [daily care review] team note, written by the Social Worker and dated 2/16/11 [no time], indicated the following: "...On Feb. [February] 15th, 2011 [Resident's name] because exit seeking and went outside on her own and wander-guard was placed on w/c [wheelchair] at this time." According to a summary documented by the Social Worker at that time, the resident did not have a history of exit seeking. There had			

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	been one incident when several residents and family members were exiting one door in November, 2010, going next door to a church for a Thanksgiving meal, that the resident had gone towards the door as well. Otherwise, no history of exit seeking. The investigation into the elopement was reviewed on 7/27/11 at 3:00 p.m. and included statements from staff. CNA #3's statement indicated he had worked the B hall and he had seen the resident approximately 7:25 p.m. to 7:30 p.m. on 2/15/11. He indicated she had set the door alarm off. CNA #3 took her back up the hall and indicated CNA #5 took her to the nurse, LPN #3 for increased supervision. CNA #4's statement indicated she worked on A hall on 2/15/11 and saw the resident outside the break room at 7:25 p.m. She indicated she brought the resident back toward the nurses station and told her the A hall door was not an exit. She indicated LPN #3 was present. CNA #5's statement indicated he was on C hall and B hall. He saw the resident attempting to exit the B hall doorway. He took her back to LPN #3, at her medication cart in the doorway of the unit dining room, for increased supervision			

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	and then went to shower another resident. He indicated it was between 7:20 and 7:30 p.m. The Dietary Aide who found the resident indicated in her statement she had clocked out at 7:49 p.m. and went directly to the front door. She indicated as she exited the front door, she heard the resident's safety belt alarm sounding. The resident was outside the building, near the administrator's office window. She called the facility and LPN #3 and LPN #1 came out to get the resident. Staff interviews did indicate the door alarm had sounded, but were unclear if it was turned off after they found her, or before. The Dietary Aide was interviewed, on 7/28/11 at 12:00 noon and repeated her observation of leaving out the front door and seeing the resident outside the administrator's window, in her wheelchair, half on the pavement and half in the grass. The investigation indicated they had done a full body assessment and the resident had no injury. The outside temperature was documented as 45 degrees. The last completed elopement risk assessment was dated 12/13/10. The facility identified the resident had impaired cognition, independently mobile, anxious episodes, inability to recognize			

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	familiar people, places and objects, had restless, irritable episodes. Their determination was she was not at risk for elopement, accepted the facility as her home, and acknowledged the need to be there at that time. The procedure for Elopement-Management, dated April 1999, with revisions January 2006 and October 2008, was provided by the Social Service Director and included, but was not limited to, the following: Policy "The Interdisciplinary Team (IDT) will re-evaluate cognitively impaired residents who have attempted, unsuccessfully or successfully, to leave the center without supervision...individualized interventions will be developed and initiated to manage the elopement behavior." Procedure "Determine the following: Was the resident trying to leave the center? If yes, ask the resident why and where they were trying to go." "Re-evaluate assessments, as applicable..." "Determine if there is a pattern to the exit seeking behavior." "Review and/or update the Elopement Plan of Care..." "review and revise individualized			

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	interventions that may prevent further elopement attempts..." 3.1-45(a)(2)			
F0332 SS=E	The facility must ensure that it is free of medication error rates of five percent or greater. Based upon observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 5 medication errors out of 44 opportunities, for an 11.36 % error rate; this affected 2 of 15 sampled residents observed for medication pass (Resident # 80, and 43), in the sample of 19, and 2 of 2 supplemental sample residents, in the supplemental sample of 3 (Residents #72 and #57), and 3 of 8 nurses observed to pass the medications (RN #2, LPN #1, LPN# 2). Findings include:	F0332	F 332 Residents #43, # 57, #72, and # 80 are being administered medications with food per physicians orders. A 100% audit of residents medications was conducted to identify physicians orders regarding medication administration with food or meals. Physician orders have been clarified to note with food unless otherwise ordered with residents meal. Residents are administered medications per physicians orders. Licensed staff have been re-educated regarding medication administration. ADON/designee reviews physicians telephone orders 5 X weekly to ensure physician orders are written correctly in regards to medications to be administered	08/27/2011

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	1. On 7/25/11 at 4:05 p.m., LPN #1 was observed administering medications to Resident #72. The medications included, but were not limited to, Calcium 600 milligrams [mg] with 400 I.U. [international units] of Vitamin D, one tablet. She was given the tablet orally with water. No food was given with the medication. Resident #72's clinical record was reviewed on 7/25/11 at 4:30 p.m. The physician's orders, dated 5/11/11, indicated "Give 1 [one] tablet orally twice daily with meals. Meal trays were observed to be passed on the unit at 5:10 p.m. on 7/25/11. 2. On 7/25/11 at 4:12 p.m., LPN #1 was observed to administer medications to Resident #80. The medications included, but were not limited to, Glyburide 5 mg two tablets, given orally with water. No food was given with the medication. The physician's orders, signed 6/11/11, were reviewed, on 7/25/11 at 4:30 p.m., and indicated, "give 2 tablets (10 mg) orally twice daily with meals." Meal trays were observed being passed at 5:10 p.m. on 7/25/11. 3. On 7/25/11 at 4:20 p.m., LPN #2 was observed administering medications to Resident #57. The medications included,		with food. Reviews will be ongoing. ADON/ designee will complete documented medication administration observations 3 X weekly for 4 weeks then 2 X weekly for 4 months. DON/designee will review audits 5 X weekly for 6 months. Identified non compliance of proper medication administration will result in 1:1 re-education with progressive discipline up to and including termination. Results of the audits are reviewed for 6 months by the QA committee for recommendations. Systemic changes will be completed by 8-27-11	

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WESTPARK REHABILITATION CENTER	25 S BOEHNE CAMP ROAD EVANSVILLE, IN47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	but were not limited to, Calcium 600 mg with Vitamin D 400 I.U. one tablet, and Potassium Chloride 10 milliequivalents [meq] one tablet, given orally with water. No food was given with the medications. The physician's orders, signed 6/14/11, were reviewed on 7/25/11 at 4:30 p.m. The orders for the Calcium with Vitamin D indicated, "Give 1 tablet orally twice daily with meals." The orders for the Potassium Chloride indicated, "Give 1 tablet orally twice daily with meals." The meal trays were observed being passed at 5:10 p.m. on 7/25/11. 4. During the 4:00 P.M. medication pass, on 7/27/11 RN #2, was observed to pass medications. RN #2 was observed to prepare and administer medications to Resident #43 at 3:45 P.M. The medication administered to Resident #43 included, but was not limited to, Aspirin 325 mg [milligrams]. The clinical record of Resident #43 was reviewed on 07/27/11 at 10:18 A.M. The June 2011 Physician's Recap included, but was not limited to, an order for, "Aspirin 325 mg tablet *take with food/meal ...give 1 tablet orally every day." In an interview with RN #2, on 07/27/11 at 3:50 P.M. indicated, "Supper is in a couple of hours."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	5. The policy and procedure for Medication Administration, dated January 2001, with revisions in September 2007 and October 2008, included, but was not limited to, the following: "The licensed nurse...will check the following to administer medication: Right medication Right dose Right dosage form Right route Right resident Right time" "Read the Medication Administration Record (MAR) for the ordered medication, dose, dosage form, route, and time." 3.1-25(b)(9)			